Mother's Name or Imprint:

MODULE 3 - DELIVERY MODULE FOR A FETAL DEATH
(COMPLETE A SEPARATE DELIVERY MODULE FOR EACH LIVE BIRTH OR FETAL DEATH.)

1. DATE OF DELIVERY/FETAL DEATH
_____ / _____ / _____
Mo. Day Yr.

2. TIME (HOUR)
_____ ☐AM ☐PM

3. DELIVERY OUTCOME (Check one)
01 ☐ Live Birth
02 ☐ Fetal Death Before Labor (Antepartum Fetal Death)
03 ☐ Fetal Death During Labor (Intrapartum Fetal Death)
04 ☐ Second Trimester Termination
05 ☐ Fetal Death During Delivery (Intrapartum Fetal Death)

4. METHOD OF DELIVER (Check all that apply)
01 ☐ Outlet Forceps
02 ☐ Low Forceps
03 ☐ Mid Forceps
04 ☐ Other Forceps
05 ☐ Vacuum
06 ☐ Spontaneous/Assisted Breech
07 ☐ Version and Extraction
08 ☐ Breech Extraction
09 ☐ Vaginal
10 ☐ C-Section, Failed Trial Labor
11 ☐ C-Section, No Trial Labor
12 ☐ VBAC
13 ☐ Failed VBAC

5. CHILD'S PLURALITY
01 ☐ Single
02 ☐ Twin
03 ☐ Triplet
04 ☐ Quad
05 ☐ Higher
Specify: _____

6. IF A MULTIPLE PREGNANCY, THIS DELIVERY WAS (1=1st, 2=2nd, 3=3rd, 4=4th, etc.)

IF MULTIPLE PREGNANCY
7. _____ WERE LIVE BIRTHS
8. _____ WERE FETAL DEATHS

QUESTIONS 9 THROUGH 13 REFER TO ONLY OTHER LIVE BIRTHS, FETAL DEATHS OR TERMINATIONS RESULTING FROM THIS PREGNANCY, DELIVERED BEFORE THIS FETUS. COMPLETE ONLY IF THE BIRTH ORDER IS GREATER THAN ONE.

9. NUMBER OF LIVE BIRTHS LIVING	10. NUMBER OF LIVE BIRTHS NOW DEAD	11. DATE OF LAST LIVE BIRTH _____ / _____	12. NUMBER OF PREGNANCY LOSSES	13. DATE OF LAST PREGNANCY LOSS _____ / _____

14. SEX OF FETUS: 01 ☐ Male 02 ☐ Female 03 ☐ Unknown

15. WEIGHT AT DELIVERY
_____ Grams OR _____ Lbs. _____ Oz.

16. CLINICAL ESTIMATE OF GESTATION
_____ Weeks

17. NAME OF PRIMARY ATTENDANT (Print)
_____
(First) (MI) (Last)

18. PLACE OF DELIVERY
01 ☐ Hospital
02 ☐ Freestanding Birthing Center
03 ☐ Clinic/Doctor's Office
04 ☐ Residence
05 ☐ Other, Specify: _____

19. PRIMARY ATTENDANT TYPE (Check one)
01 ☐ MD
02 ☐ DO
03 ☐ CNM
04 ☐ Other Midwife
05 ☐ Other, Specify: _____

20. FACILITY NAME (If delivery did not take place at this facility):

21. CONGENITAL ANOMALIES OF FETUS (Check all that apply)

CENTRAL NERVOUS SYSTEM
01 ☐ Anencephalus
02 ☐ Spina Bifida/Meningocele
03 ☐ Hydrocephalus
04 ☐ Microcephalus
05 ☐ Other Central Nervous System Anomalies, Specify: _____

HEART
06 ☐ Heart Malformations
07 ☐ Other Circulatory/Respiratory Anomalies, Specify: _____

GASTROINTESTINAL
08 ☐ Rectal Atresia/Stenosis
09 ☐ Tracheo-Esophageal Fistula/ Esophageal Atresia
10 ☐ Omphalocele/Gastroschisis
11 ☐ Other Gastrointestinal Anomalies, Specify: _____

UROGENITAL
12 ☐ Malformed Genitalia
13 ☐ Renal Agenesis
14 ☐ Other Urogenital Anomalies, Specify: _____

MUSCULOSKELETAL
15 ☐ Cleft Lip/Palate
16 ☐ Polydactyly/Syndactyly/Adactyly
17 ☐ Club Foot
18 ☐ Diaphragmatic Hernia
19 ☐ Other Musculoskeletal/ Integumental Anomalies, Specify: _____

CHROMOSOMAL
20 ☐ Down Syndrome
21 ☐ Other Chromosomal Anomalies, Specify: _____

NOT COVERED ELSEWHERE
22 ☐ Other, Specify: _____
23 ☐ Unknown
00 ☐ None

(*N.J.S.A. 26:8-40.20 ET SEQ., SPECIFICALLY 26:8-40.26 REQUIRES BIRTH DEFECTS AND OTHER SPECIFIED CONDITIONS TO BE REPORTED TO THE NEW JERSEY BIRTH DEFECTS REGISTRY.)

Name of Individual Completing This Module	Signature	Date